REVITALIZE
INFUSION CENTER

Skyrizi®

Infusion Order Form

Patient Information:

_____	_____	_____
Patient Name	**DOB**	**Phone Number**

Medical Information:

Primary Diagnosis:

☐ Crohn's Disease (CD) ICD-10 Code: K50._____

☐ Ulcerative colitis (UC) ICD-10 Code: K51._____

☐ Other_____ ICD-10 Code: _____

Allergies: _____(or attach list)

Clinical Information – Please include with Completed Order Form:

- Patient Demographic and Insurance Information
- Clinical notes supporting primary diagnosis
- Active Medication List
- Relevant labs and tests including baseline liver enzymes and bilirubin
- Documentation of previously trailed therapies and reason for DC
- Required Information:
  - TB Screening Results
  - If a washout period is desired, the therapy can be initiated on or after: _____

Height: _____

Weight: _____

Skyrizi (risankizumab-rzza) Orders:

☐ **Crohn's Disease (CD):**

Infuse 600 mg intravenously on Week 0, Week 4 and Week 8 to provide a total of three (3) doses

☐ **Ulcerative colitis (UC):**

Infuse 1,200 mg intravenously on Week 0, Week 4 and Week 8 to provide a total of three (3) doses

Pre-Medication Orders: _____

*No pre-medications are recommended based on the manufacturer's PI

Lab Orders: ☐ Infusion center to obtain liver enzymes and bilirubin at ☐ baseline and/or ☐ week ____ during induction dosing

☐ Other:_____

Prescriber Information:

By signing this form and requesting these services from Revitalize, I authorize Revitalize and it's clinical team to serve as my Prior Authorization Agent with the Patient's Insurance Provider(s).

_____	_____
Prescriber's Signature	**Date**
_____	_____
Prescriber's Printed Name	**Contact Phone #:**

For Information About Revitalize and or Infusion Plus, please scan the QR code below:

Revitalize | Revitalize Locations | InfusionPlus